

9320

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 5yrs. 8mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1829 N. Dallas Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle J. Last ANDERSON		4. DATE OF DEATH Month September Day 13, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1856
9. AGE (In years last birthday) 101 yrs.		IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Holler Anderson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis, simple deterioration. Fractured pubic bone.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 14, 1952 , to September 13, 1957 , that I last saw the deceased alive on September 12, 1957 , and that death occurred at 1:12 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/13/57 ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/16/57	22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Tichenor & Sons - Balt.		24a. REC'D BY REGISTRAR DATE SEP 16 1957	
24b. REGISTRAR'S SIGNATURE Harry Myers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

RECEIVED
 SEP 17 1957
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09327

9321

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Sykesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>OLIVIA</i> Middle <i>FLORENCE</i> Last <i>APPLEBY</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>25</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-28-1874</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles M. Ridgely</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Ridgely</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Daughter - Mrs. Hoides</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest, bronchial</i> <i>334X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>pneumonia, arteriosclerosis, hypertension</i> (c) <i>left bundle branch block</i>		INTERVAL BETWEEN ONSET AND DEATH <i>June 57 to Sept 57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1954</i> , 19 <i>Sept</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>25 Sept</i> , 19 <i>57</i> , and that death occurred at <i>9:45 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.		ADDRESS (Street, city or town, state) <i>Sykesville, MD</i> DATE SIGNED <i>25 Sept 57</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		<i>SYKESVILLE, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>9-28-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Providence</i>	
22d. LOCATION (City, town, or county) (State) <i>Charles, Howard, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i> ADDRESS <i>Sykesville, MD</i>		24a. REC'D BY REGISTRAR DATE <i>7-26-57</i>	
24b. REGISTRAR'S SIGNATURE <i>C. H. H. H.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9322

Item 7 FilmG220 9-30-57 et

CERTIFICATE OF DEATH

09328

Reg. Dist. No.

Items 8 & 9 G221 10/15/57 GE

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 9mos. 25days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3y01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1824 E. Pratt Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle BARAN Last BARAN		4. DATE OF DEATH Month September Day 18, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 May 18, 1887
9. AGE (In years last birthday) 70 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Andrew Baran		14. MOTHER'S MAIDEN NAME Mary Baran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with alcohol intoxication with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Approx. 2 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 23, 19 55, to September 18 19 57, that I last saw the deceased alive on September 17, 19 57, and that death occurred at 8:40A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 9/18/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/21/57	
22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Bohowski		ADDRESS 2818 E. Balto. St	
24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE C. Harry Keays	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

2000

BUREAU V. S.

SEP 24 1957

RECEIVED

9323

CERTIFICATE OF DEATH

09329

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Y 01-4	
d. STREET ADDRESS 508 Cording Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Margaret Middle Miller Last BEVANS		4. DATE OF DEATH Month September Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS. Days 82 Hours 82 Min. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19, 1957 , to Sept. 10, 1957 , that I last saw the deceased alive on Sept. 9, 1957 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/10/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
Burial	9-13-57	Parkwood	Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Remond Ruck		ADDRESS 305 Harford	
24a. REC'D BY REGISTRAR DATE 9-10-57		24b. REGISTRAR'S SIGNATURE E. Harry Kier	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

File No. 10

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		1957		Home	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Education	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher		High School	
Date of Birth		Date of Death		Time of Death		Place of Birth		Place of Death		Place of Burial	
1912		1957		10:00 AM		Baltimore, MD		Baltimore, MD		Baltimore, MD	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Home		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

SEP 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 8 m 11 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18, 3401-4 d. STREET ADDRESS 2307 Aisquith Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Noble Middle Biscoe Last Biscoe				4. DATE OF DEATH Month 9 Day 22 Year 19 57			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-93	
9. AGE (in years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 12		IF UNDER 24 HRS. Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) auto salesman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Biscoe				14. MOTHER'S MAIDEN NAME Martha Pickerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-10-6636		17. INFORMANT S.S. Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Pulmonary Embolism 936.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left femur DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with psychotic reaction of unknown cause							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Do not know					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9-10 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital - Sykesville		20f. (City or town) (County) (State) City Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-22-57	
EXAMINER'S NAME (Type) James T. Marsh				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 25		22c. NAME OF CEMETERY OR CREMATORY Stedlersville		22d. LOCATION (City, town, or county) (State) Stedlersville Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar A. Lane ADDRESS Church Hill				24. REC'D BY REGISTRAR SEP 26 1957		24b. REGISTRAR'S SIGNATURE C. H. Weer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. HARRIS		38		M		W		1957		BOSTON	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL EXAMINER		SIGNATURE	
1000 N. ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
1919		1957		10:00		10:00		10:00		10:00	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
1919		1957		10:00		10:00		10:00		10:00	

BUREAU V. 3

SEP 25 1957

RECEIVED

9325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 80

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle BLACKSTEN Last BLACKSTEN				4. DATE OF DEATH Month SEPT Day 14 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 8 - 1879		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER OWN FARM				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN H BLACKSTEN				14. MOTHER'S MAIDEN NAME LIZA HAWK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILBUR BLACKSTEN Address MD NEW WINDSOR			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation - by hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suicide DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE S. LUTHER BARE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/16/57	
EXAMINER'S NAME (Type) S. LUTHER BARE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 17 - 1957		22c. NAME OF CEMETERY OR CREMATORY PIPE CREEK		22d. LOCATION (City, town, or county) (State) CARROLL CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hartzler & Sons New Windsor				24a. REC'D BY REGISTRAR DATE Sept 14/57		24b. REGISTRAR'S SIGNATURE Ernest S. Brouchet S. Reg.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1957

BUREAU V. S.

9326

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>				c. LENGTH OF STAY IN 1b <u>12 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph H. Bradshaw</u>				4. DATE OF DEATH Month Day Year <u>Sept 7 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 28 - 1870</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Bradshaw</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-14-8848</u>		17. INFORMANT Address <u>Mrs Mamie Bradshaw Manchester Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>1</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/22/1947</u> to <u>9/5/1957</u> , that I last saw the deceased alive on <u>Sept 1</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.H. Foard</u>				DATE SIGNED <u>9/6/57</u>			
PHYSICIAN'S NAME (Type) <u>W.H. Foard M.D.</u>				ADDRESS (Street, city or town, state) <u>Manchester, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. C. Tipton</u>				24a. REC'D BY REGISTRAR DATE <u>Sept 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. H. P. Danner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 11 1957

RECEIVED

Reg. Dist. No.

9327

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/5S

CERTIFICATE OF DEATH

MARKLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		October 10, 1957		Home	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Education	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher		High School	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Place of Death	
January 1, 1912		Baltimore, Md.		October 8, 1957		October 10, 1957		October 10, 1957		Home	

John Doe
Heart Disease
Myocardial Infarction
Coronary Atherosclerosis
Natural
Teacher
High School

BUREAU V. S.

SEP 19 1957

RECEIVED

Handwritten signature and notes at the bottom of the page.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9328

Reg. Dist. No. 81

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH

a. COUNTY

CARROLL

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

UNION BRIDGE

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Pa.

b. COUNTY

Franklin

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Greencastle 75X-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

UNION BRIDGE, MD.

d. STREET ADDRESS

RDI - Greencastle, Pa.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First CHARLES

Middle W

Last BRYAN

4. DATE OF DEATH

Month Sept Day 27 Year 1957

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 15, 1896

9. AGE (In years last birthday)

61 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

10b. KIND OF BUSINESS OR INDUSTRY

Electrical Work

11. BIRTHPLACE (State or foreign country)

Marion, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carl Bryan

14. MOTHER'S MAIDEN NAME

Harriett Grimes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or in home) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

223-28-1872

17. INFORMANT

Address RDI Mrs. Anna Bryan Greencastle, Pa.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

MIN.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour o. m. p. m.

19

20d. INJURY OCCURRED

While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James T. Marsh

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/27/57

EXAMINER'S NAME (Type)

JAMES T. MARSH

22a. BURIAL - CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/30/57

22c. NAME OF CEMETERY OR CREMATORY

Macedonia Cem.

22d. LOCATION (City, town, or county)

Franklin Co., Pa.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

A. E. Minnich - Greencastle

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

Leslie Z. Repp

Pa. SEP 30 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DIVISION OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 30 1957
BUREAU V. S.

9329

CERTIFICATE OF DEATH

0933581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAISY MAY COLEMAN</u>				4. DATE OF DEATH Month Day Year <u>SEPT 25 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/24/1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE ANGELL</u>				14. MOTHER'S MAIDEN NAME <u>SARAH JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>RENO COLEMAN, KEYMAR, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan -</u> , 19 <u>57</u> , to <u>9-25-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-21-</u> , 19 <u>57</u> , and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Union Bridge</u>				DATE SIGNED <u>9-25-57</u>			
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Thomas H. Legg, M.D.</u>				<u>Union Bridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hubbs</u> ADDRESS <u>Union Bridge Md.</u>				24a. REC'D BY REGISTRAR <u>9/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>Lester L. Rupp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

BUREAU V. 3

SEP 30 1957

RECEIVED

CERTIFICATE OF DEATH

0933674

Reg. Dist. No.

9330

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr. 6mos. 14days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Davis Last COURTNEY				4. DATE OF DEATH Month September Day 16, Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. XXXXXXXXXXXX XXXXXXXXXXXX DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 13, 1877	
9. AGE (In years last birthday) yrs. 80		10. AGE (In years last birthday) yrs. 80		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY -			
13. FATHER'S NAME James D. Courtney				14. MOTHER'S MAIDEN NAME Catherine Courtney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombocytopenia purpura 420.0 XXXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Days Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 2, 19 56 , to September 16, 1957 , that I last saw the deceased alive on September 16, 19 57 , and that death occurred at 9:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/16/57							
ACTUAL SIGNATURE Agustin del Campo				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-1957		22c. NAME OF CEMETERY OR CREMATORY mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Cline & Son				ADDRESS Frederick - Md.		24a. REC'D BY REGISTRAR DATE Sept 17, 1957	
24b. REGISTRAR'S SIGNATURE Harry E. Weir				EJ			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—JANUARY 19

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JAN 19 1957		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIED		JAN 19 1957		BALTIMORE, MD.		JAMES H. HARRIS		JAN 19 1957		BALTIMORE, MD.	
EDUCATION		SCHOOL		DEGREE		NAME OF SCHOOL		DATE OF GRADUATION		PLACE OF GRADUATION	
HIGH SCHOOL		BALTIMORE, MD.		B.S.		BALTIMORE, MD.		JAN 19 1957		BALTIMORE, MD.	
OCCUPATION		BUSINESS		NAME OF EMPLOYER		DATE OF EMPLOYMENT		PLACE OF EMPLOYMENT		DATE OF DEATH	
BUSINESS		BALTIMORE, MD.		JAMES H. HARRIS		JAN 19 1957		BALTIMORE, MD.		JAN 19 1957	
CAUSE OF DEATH		HEART		NAME OF PHYSICIAN		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF DEATH	
HEART		BALTIMORE, MD.		JAMES H. HARRIS		JAN 19 1957		BALTIMORE, MD.		JAN 19 1957	
MANNER OF DEATH		NATURAL		NAME OF CORONER		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF DEATH	
NATURAL		BALTIMORE, MD.		JAMES H. HARRIS		JAN 19 1957		BALTIMORE, MD.		JAN 19 1957	
SIGNATURE OF DECEASED		NAME OF WITNESS		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAMES H. HARRIS		JAN 19 1957		BALTIMORE, MD.		JAN 19 1957		BALTIMORE, MD.	

BUREAU V. S.

SEP 20 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	c. LENGTH OF STAY IN 1b <u>15 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hampstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>L-KURTZ-CULLISON</u> First Middle Last		4. DATE OF DEATH <u>Sept 18</u> Month Day Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17-1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>Geo R Cullison</u>		14. MOTHER'S MAIDEN-NAME <u>Rachel Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-22-5484</u>	
17. INFORMANT <u>Mrs James Harris, Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Disease to Angina</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>47</u> , to <u>Sept. 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 16</u> , 19 <u>47</u> , and that death occurred at <u>1:30 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		DATE SIGNED <u>9/20/57</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Tipton, Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Henry Jones</u>	
ADDRESS		DATE <u>9/27/57</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mostly illegible due to blurriness.

BUREAU V. 3

SEP 24 1957

RECEIVED

9332

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2mos. 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1904 Barclay Street, Balto. 18.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sadie Jane Middle Dolan Last DAHL				4. DATE OF DEATH Month September Day 30 , Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1890		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Dolan				14. MOTHER'S MAIDEN NAME Annie Pyle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Years		INTERVAL BETWEEN ONSET AND DEATH Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntional psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1957 , to September 30, 1957 , that I last saw the deceased alive on September 30, 1957 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 9/30/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 4-1957		22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connelly				ADDRESS Essex 21 Md.		24a. REC'D BY REGISTRAR DATE 9/30/57	
				24b. REGISTRAR'S SIGNATURE C.H. Green			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1900"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "Oct 3, 1937"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	

BUREAU V. S.

OCT 3 1937

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

76

9333

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 109 LIBERTY ST EXT	
3. NAME OF DECEASED (Type or print) First ULYSSES Middle SIMPSON Last E BAUGH		4. DATE OF DEATH SEPTEMBER 21 1957	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 2, 1877
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELLER - BANKING (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JOEL E BAUGH		14. MOTHER'S MAIDEN NAME SARAH ROUTSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-034034	
17. INFORMANT WIFE		Address 109 LIBERTY ST EXT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 ACUTE CONGESTIVE HEART FAILURE DUE TO (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DIS. DUE TO (c) 2 YEARS		INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:20 p.m. SEPT 21 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 20, 1957 , to SEPT 21, 1957 , that I last saw the deceased alive on SEPT 20, 1957 , and that death occurred at 3:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel J. Welliver		ADDRESS (Street, city or town, state) 19 N. CHURCH ST WESTMINSTER MARYLAND	
PHYSICIAN'S NAME (Type) Daniel J. Welliver		DATE SIGNED 9/21/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT 23 1957	22c. NAME OF CEMETERY OR CREMATORY ST CARROLLTON CEM.	22d. LOCATION (City, town, or county) (State) RURAL WESTMINSTER MD.
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. Westminster Md		24a. REC'D BY REGISTRAR DATE 9-22-57	24b. REGISTRAR'S SIGNATURE Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

SEP 24 1957

BUREAU V. 3

RECEIVED

9334

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield State Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3v01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sykesville, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Vincent</u> Last <u>ELLIOTT</u>		4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert O. Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Philpot</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition with edema</u> <u>539.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophageitis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis, agitated depressed type, plus diabetes.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12, 1952</u> , to <u>September 11, 1957</u> , that I last saw the deceased alive on <u>September 11, 1957</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>9/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Towson</u> <u>29</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Seewald</u>		24a. REC'D BY REGISTRAR <u>9/11/57</u>	
ADDRESS <u>108 W. North Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

09341

Reg. Dist. No. 74

9335

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>30 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Sykesville</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>JANE</i> Middle <i>E.</i> Last <i>EVANS</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>13</i> Year <i>1957</i>			
5. SEX <i>AF</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 25, 1888</i>	9. AGE (In years last birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Samuel Woodward</i>				14. MOTHER'S MMDEN NAME <i>Ida Grimm</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Robert Evans - Sykesville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest, Arteriosclerosis</i> DUE TO <i>260x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis, Arteriosclerosis</i> DUE TO (c) <i>Diabetes</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1957 to Sept 57</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1957</i> to <i>Sept</i> 1957, that I last saw the deceased alive on <i>13 Sept</i> 1957, and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.				ADDRESS (Street, city or town, state) <i>Sykesville, Md</i> DATE SIGNED <i>13 Sept 57</i>			
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>				SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>9-15-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Morgan Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Woodbine, Carroll, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Luther A. Haight</i> ADDRESS <i>Sykesville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>9-14-57</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry Weber</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. S.

SEP 17 1957

RECEIVED

9336

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 y 10 m 4 d			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14, Md.				3y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 3202 Hamilton Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Francis Last Evans				4. DATE OF DEATH Month 9 Day 21 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) musician		10b. KIND OF BUSINESS OR INDUSTRY York		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Francis Evans				14. MOTHER'S MAIDEN NAME Florence Manchester			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 11/12/42-2/17/43 216-01-4493		17. INFORMANT Hospital Records, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pharynx 148x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with chronic alcoholic deterioration 307x							INTERVAL BETWEEN ONSET AND DEATH 5 months plus
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20-54 , 19 54 , to 9-20- 1957 , that I last saw the deceased alive on 9-20- 1957 , and that death occurred at 1:59 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 9-21-57							
ACTUAL SIGNATURE Edmund B. Lusthaus				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-57		22c. NAME OF CEMETERY OR CREMATORY National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henderson - North and Broadway				24a. REC'D BY REGISTRAR DATE 9-23-57		24b. REGISTRAR'S SIGNATURE C. Harry Eder	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

COQ1-SJ

326

BUREAU V. S.

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

09343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>81 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hosp. Md</u>				d. STREET ADDRESS <u>3409 Greenway St. Balto 18</u>			
3. NAME OF DECEASED (Type or print) First <u>Claudia</u> Middle <u>Marie</u> Last <u>Everitt</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>2-4-1876</u>		9. AGE (In years lost birthday) <u>81</u> yrs.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Everitt GREASEN</u>				14. MOTHER'S MAIDEN NAME <u>Mary Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs G. Wharton Brown-3409 Greenway St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>due to Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23-55</u> , 19 <u>57</u> , to <u>9-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-21</u> , 19 <u>57</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gertrude Sourenfeldt M.D. Springfield State Hospital Sykesville Md.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Gertrude Sourenfeldt M.D. Springfield State Hospital Sykesville Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tichner & Sons - North La. Ave. Balto Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>C Harry Heery</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

SEP 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09344

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

26

9338

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster RD#7</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>GATELY</u> Last <u>FLYNN</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1909</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>William L. Flynn</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Gately Flynn, Westminster, Md. RD#7</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> XDETO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Russell S. Fisher</u>				DATE SIGNED <u>9/4/57</u>			
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept 6 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md. RD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 9 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9339

09345

Reg. Dist. No. 80

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEXTOWN</u>		c. LENGTH OF STAY IN 1b <u>MINUTES</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 NEW WINDSOR RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAIN STREET</u>				d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>VIOLET</u> Middle <u>KOONS</u> Last <u>FUSS</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>15</u> Year <u>1957</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>NOV 1 - 1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>JOHN M KOONS</u>			
14. MOTHER'S MAIDEN NAME <u>ELMORE M HANN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>219-14-7951</u>		17. INFORMANT <u>MAUDE KOONS</u> Address <u>RURAL NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>none</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James J. Morsch</u>		EXAMINER'S NAME (Type) <u>James J. Morsch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>9/15/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 18 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>REFORMED</u>	
22d. LOCATION (City, town, or county) (State) <u>TANEXTOWN MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>DR Hartzler & Sons New Windsor Md</u>			
24a. REC'D BY REGISTRAR <u>Sept 16/57</u>		24b. REGISTRAR'S SIGNATURE <u>Ernie Benedict</u>			

2nd

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

RECEIVED
SEP 17 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0934674
Reg. Dist. No.

CERTIFICATE OF DEATH

9340

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 14 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE H.		d. STREET ADDRESS 1525 NORTHGATE Rd.	
3. NAME OF DECEASED (Type or print) First BERTHA Middle FLORENCE Last GARTON		4. DATE OF DEATH Month SEPT Day 13 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH V-19-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) ILLINOIS
13. FATHER'S NAME HENRY C. SCHLUETER		14. MOTHER'S MAIDEN NAME Anna Brenker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address ANNA GARTON CORDETT, AS AUNT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS ASSOCIATED W SENILE BRAIN DISEASE, W PSYCHOTIC REACTION			INTERVAL BETWEEN ONSET AND DEATH 15 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) — (County) — (State) —			
21. I certify that I attended the deceased from VII-6, 56 , 19 56 , to IX-15 , 19 57 , that I last saw the deceased alive on IX-15 , 19 57 , and that death occurred at 7:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertud Soumenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Md.	
PHYSICIAN'S NAME (Type) Gertud Soumenfeldt M.D. Springfield State Hospital, Sykesville, Md.		DATE SIGNED SEP 16 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/57	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons. Balto. 17, Md.		24a. REC'D BY REGISTRAR SEP 16 1957 24b. REGISTRAR'S SIGNATURE C. Harry Keen	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

File No. 10

MARYLAND

CARROLL

BALTIMORE 18

RESIDENCE IN MARYLAND

2100 EIGHTH STREET N. 1822 WILKINSON AVENUE N.

BERTHA FLORENCE CARTON

F W X V-14-18 19

USA

ILLINOIS

HENRY SCHLUTTER

ANNA CARTON CORDETT

ARTERIO-SCLEROTIC CARDIOPATHY

DISEASE

12 YEARS

COB ALLEGED TO BE THE SAME PERSON AS THE ONE WHO WAS

BUREAU V. S.

SEP 17 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 75

9341

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glyndon 03x2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>GORMAN</u> Last <u>GORMAN</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 2, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel GORMAN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN BURNS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs John K. Shaw Jr; Glyndon MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 420.1 DUE TO <u>Anterior Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1954</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 2</u> , 19 <u>57</u> , to <u>Sept 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 24</u> , 19 <u>57</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>9/27/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 30, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cath.</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin A. Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>Sept 29/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. WRS-Denmer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-54-1

DATE OF DEATH
PLACE

CAUSE OF DEATH
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BUREAU V. 2

OCT 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 189348

9342

CERTIFICATE OF DEATH

Reg. Dist. No.

82

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b 28 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Mt. Airy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Church St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle FRANK Last HARRIS, SR				4. DATE OF DEATH Month 9- Day 10- Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-1896		9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic (retired)		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Scheel Harris				14. MOTHER'S MAIDEN NAME Rovella Hare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) W.W. 1 213-36-7613		17. INFORMANT Mrs. Marion Harris,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 148X Carcinoma of Throat DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 57 to Sept 10, 19 57 , that I last saw the deceased alive on Sept 10, 19 57 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9-10-57							
ACTUAL SIGNATURE C. M. Waltz		M.D. C. M. Waltz					
PHYSICIAN'S NAME (Type) C. M. Waltz							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-12-1957		22c. NAME OF CEMETERY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 1957	
				24b. REGISTRAR'S SIGNATURE Robt. A. Smith			

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09349

Reg. Dist. No. 33

76

9343

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown RD3				c. LENGTH OF STAY IN 1b 10 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Emory Rd				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED First Jacob Middle A. Last Helwig				4. DATE OF DEATH Month Sept. Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.	IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John O. Helwig				14. MOTHER'S MAIDEN NAME Marget Vance			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-20-7445		17. INFORMANT Mrs. Dora Helwig, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.-V. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemiplegia DUE TO (c) Multiple bed sores						INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 1/2 mos. 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. none	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) none	(County) none	(State) none		
21. I certify that I attended the deceased from 1-5-45 , 19____, to 9-13-57 , 19____, that I last saw the deceased alive on 9-12-57 , 19____, and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 9-16-57							
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.					
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 16/57	22c. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery	22d. LOCATION (City, town, or county) Finksburg	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 9-16-57		24b. REGISTRAR'S SIGNATURE Harriet J. Miller	

CERTIFICATE OF DEATH

33

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
JAMES J. HARRIS		45		M		W		10-10-27		New York, N.Y.		Heart Disease		J. J. Harris		J. J. Harris	
Date of Birth		Place of Birth		Married		Occupation		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
10-10-27		New York, N.Y.		Yes		Teacher		10-10-27		New York, N.Y.		Heart Disease		J. J. Harris		J. J. Harris	
Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar		Date of Death		Place of Death		Cause of Death		Signature of Physician	
10-10-27		New York, N.Y.		Heart Disease		J. J. Harris		J. J. Harris		10-10-27		New York, N.Y.		Heart Disease		J. J. Harris	

BUREAU V. 5

SEP 17 1957

RECEIVED

9-16-27

3344
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 808 S. Belnord Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle S. Last HOKE				4. DATE OF DEATH Month September Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-96 August 23, 1898	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 6 Days 13 Hours 59 Min.		IF UNDER 24 HRS. Months 6 Days 13 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no yes World War I				16. SOCIAL SECURITY NO. 217-09-3879		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic heart disease DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH Hours Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome of unknown cause.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month September Day 17 Year 1957 Hour 3:10 o. m. A p. m. M				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital	
20f. (City or town) Baltimore				(County) Baltimore		(State) Maryland	
21. I certify that I attended the deceased from September 17, 1957 , to September 25, 1957 , that I last saw the deceased alive on September 24, 1957 , and that death occurred at 3:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				DATE SIGNED 9/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-27-1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Maryland				(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Kaczorowski				ADDRESS 2525 Fleet Street		24a. REC'D BY REGISTRAR SEP 30 1957	
24b. REGISTRAR'S SIGNATURE C. Harry Keers							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH - BALTIMORE

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BUREAU V. S.

SEP 30 1957

RECEIVED

0935181
Reg. Dist. No.

9345

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LOCUST ST</u>				d. STREET ADDRESS <u>LOCUST ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE L HOUCK</u>				4. DATE OF DEATH Month Day Year <u>SEPT 12 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/25/1887</u>	
9. AGE (In years last birthday) yrs. <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JACOB R. HOUCK</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE HOUCK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ROY W. HOUCK, DETOUR, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-1-</u> , 19 <u>57</u> , to <u>9-12-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-12-</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge, MD</u>			
DATE SIGNED <u>9-11-57</u>				PHYSICIAN'S NAME (Type) <u>Thomas H. Legg M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>9/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE CEM.</u>	
22d. LOCATION (City, town, or county) (State) <u>WOODSBORO MD</u>				24a. REC'D BY REGISTRAR <u>9/14/57</u>			
24b. REGISTRAR'S SIGNATURE <u>Edie L. Repp</u>				24c. REGISTRAR'S SIGNATURE <u>Edie L. Repp</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED
JAMES EARL RAY

DATE OF DEATH
APRIL 4, 1968

AGE
35

SEX
MALE

RACE
WHITE

DATE OF BIRTH
APRIL 10, 1932

PLACE OF BIRTH
MOBILE, ALABAMA

DATE OF DEATH
APRIL 4, 1968

PLACE OF DEATH
MEMPHIS, TENNESSEE

DATE OF DEATH
APRIL 4, 1968

PLACE OF DEATH
MEMPHIS, TENNESSEE

DATE OF DEATH
APRIL 4, 1968

PLACE OF DEATH
MEMPHIS, TENNESSEE

DATE OF DEATH
APRIL 4, 1968

PLACE OF DEATH
MEMPHIS, TENNESSEE

DATE OF DEATH
APRIL 4, 1968

PLACE OF DEATH
MEMPHIS, TENNESSEE

DATE OF DEATH
APRIL 4, 1968

PLACE OF DEATH
MEMPHIS, TENNESSEE

BUREAU V. 2

SEP 16 1967

RECEIVED

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CERTIFICATE OF DEATH

0935274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle John Last Howard				4. DATE OF DEATH Month 9 Day 7 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1927	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 2-28-44-7537		17. INFORMANT S.S. Hospital Records			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO lying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 8-13- 1957 , to 9-6- 1957 , that I last saw the deceased alive on 9-6- 1957 , and that death occurred at 6:23 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9-7-57 ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) 989-571	22b. DATE THEREOF 9-9-57	22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill	22d. LOCATION (City, town, or county) Monrovia, Md	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md			24a. RECEIVED BY REGISTRAR SEP 10 1957 24b. REGISTRAR'S SIGNATURE C. Harry R...				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

SEP 10 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please
executing this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20b Film 220 9-6-57 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09353 74
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Marriottsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bartholow Road				d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) BERNARD CARL JACKSON		4. DATE OF DEATH Month Day Year Sept. 1, 1957 19		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1945	9. AGE (in years last birthday) 12 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
13. FATHER'S NAME Carl Hodge		14. MOTHER'S MAIDEN NAME Ethel Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ethel Jackson, Marriottsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fract. Skull - Multiple fracs 813 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Left fallen (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rode his bicycle into an automobile			
20c. TIME OF INJURY Month, Day, Year 12:15 - 9-1 1957 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bartholow Road	20f. (City or town) Sykesville	(County) Carroll	(State) Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/1/57	
EXAMINER'S NAME (Type) JAMES T MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-4-57	22c. NAME OF CEMETERY OR CREMATORY West Liberty	22d. LOCATION (City, town, or county) (State) Alpha, Md		
23. FUNERAL DIRECTOR'S SIGNATURE F.C.Higinbotham, Ellicott City, Md.		ADDRESS		24. REGISTRAR'S SIGNATURE SEP 3 1957 Colony Heers	

BUREAU V. B.

SEP 3 1957

RECEIVED

9348

CERTIFICATE OF DEATH

09354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Hykesville</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Hykesville x 2</u> d. STREET ADDRESS <u>Oldenburg.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>JOHNSON</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1957</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 30, 1955</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank T. Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Phyllis Broadhurst</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>M. Frank T. Johnson - Hykesville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-Intestinal Hemorrhage</u> <u>756.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cirrhosis of liver and spleen</u> DUE TO (c) <u>aplasia of bile ducts</u>										INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>2 years</u> <u>congenital</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-17, 1955</u> , to <u>9-14, 1957</u> , that I last saw the deceased alive on <u>9-14, 1957</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SYKESVILLE Md.</u> DATE SIGNED <u>9-15-57</u>											
ACTUAL SIGNATURE <u>Bertrand R. Gau</u> M.D.						PHYSICIAN'S NAME (Type) <u>Bertrand R. GAU</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>				22d. LOCATION (City, town, or county) (State) <u>Oldenburg, Carroll, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Hykesville, Md.</u> ADDRESS						24a. REC'D BY REGISTRAR DATE <u>9-16-57</u>			24b. REGISTRAR'S SIGNATURE <u>C. Harry Wren</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. 5

SEP 19 1957

RECEIVED

9349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINWOOD				c. LENGTH OF STAY IN 1b YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FANNIE Middle ELLEN Last JONES				4. DATE OF DEATH Month SEPT Day 12 Year 1957			
5. SEX F		6. COLOR OR RACE COL		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 29-1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRESS		10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN DAVIS				14. MOTHER'S MAIDEN NAME ELLEN TUCKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address MRS HOWARD DAVIS UNION BRIDGE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Cardio-vascular 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/13/57 , 19___, to 9/12/57 , 19___, that I last saw the deceased alive on 9/7/57 , 19___, and that death occurred at 8 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. E. Robertson				ADDRESS (Street, city or town, state) New Windsor, Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 15-1957		22c. NAME OF CEMETERY OR CREMATORY MT JOY		22d. LOCATION (City, town, or county) (State) UNIONTOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Hartzler & Sons				ADDRESS New Windsor, Md.		24a. REC'D BY REGISTRAR DATE SEP 18 1957	
				24b. REGISTRAR'S SIGNATURE Ernie Benedict			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 16 1957

RECEIVED

9350

CERTIFICATE OF DEATH

Reg. Dist. No. 09356 76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carrollton Rural</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dutrow Rd</u>		d. STREET ADDRESS <u>1 Dutrow Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDRIA (ALICE) KIAUNIS</u>		4. DATE OF DEATH Month Day Year <u>September 7 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Francis Baravickas</u>		14. MOTHER'S MAIDEN NAME <u>Helex Bejaikis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Stelen Jakimovics, Curleton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma Lung.</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Carcinoma of Pancreas</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 7</u> , 19 <u>57</u> , to <u>Sept 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 5</u> , 19 <u>57</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>9/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph F. Bush MD</u>		<u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>4430 Belair Rd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u> ADDRESS <u>46 Lollins St.</u>		24a. REC'D BY REGISTRAR <u>SEP 9 1957</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
SEP 9 1957
BUREAU V. S.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

9351

09357

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL OR and give nearest town) New Windsor		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) New Windsor			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print) EDGAR WILLIAM KOONTZ				4. DATE OF DEATH (Month) (Day) (Year) Sept. 19, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED Married	8. DATE OF BIRTH June 18, 1899	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Milton Koontz				14. MOTHER'S MAIDEN NAME Annie Snook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. 214-28-2217		17. INFORMANT & ADDRESS Reta H. Koontz, New Windsor, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4201 IMMEDIATE CAUSE (A) Coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH month	
ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerotic C.V. disease						2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1956, to Sept 19, 1957, that I last saw the deceased alive on Sept 18, 1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above.							
SIGNATURE James J. Marsh				DATE SIGNED 9/21/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 9/22/57		NAME OF CEMETERY OR CREMATORY Winters Cemetery	
24. REC'D BY REGISTRAR Sept 23/57				REGISTRAR'S SIGNATURE Gregory S. Benedict		LOCATION (City, town, or county) Carroll County, Md.	
				25. FUNERAL DIRECTOR'S SIGNATURE John R. Ray		ADDRESS New Windsor, Md.	

CERTIFICATE OF DEATH

9331

NAME OF DECEASED		SEX		AGE	
John Doe		Male		45	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
123 Main St, Baltimore, Md		Teacher		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
Sep 20, 1957		Home		Natural	
TIME OF DEATH		HOURS		MINUTES	
10:00 AM		10		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE	
Sep 20, 1957		10:00 AM		Home	

BUREAU V. S.

SEP 25 1957

RECEIVED

ENCLOSURE

VS A15 (4)
15M 9/55

VS A15 (4)
15M 9/55

9352

09358

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x / Finksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Niner Road		d. STREET ADDRESS / Niner Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Esther Middle Louise Last Lentzner		4. DATE OF DEATH Sept. 25 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1917	9. AGE (In years last birthday) yrs. 40	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto. County, Md.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Lenwood Cross		14. MOTHER'S MAIDEN NAME Gertrude Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT James Z. Lentzner Address Finksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		b. Acute Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westminster, Maryland	
20f. (City or town) Westminster, Maryland		(County) Westminster		(State) Md.	
21. I certify that I attended the deceased from 9/25 , 19 57 , to 9/25 , 19 57 , that I lost saw the deceased alive on 9/25 , 19 57 , and that death occurred at 1:45 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 79 W. Main St. Westminster, Md.		DATE SIGNED 9/26/57	
ACTUAL SIGNATURE S. Luther Bare		M.D. Westminster, Maryland			
PHYSICIAN'S NAME (Type) S. Luther Bare					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-57		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
22d. LOCATION (City, town, or county) Gamber, Maryland		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 9-28-57	
24b. REGISTRAR'S SIGNATURE Harriet Miller					

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
CITY OR TOWN		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS DEATHS	
CAUSE OF DEATH		MEDICAL HISTORY	
TREATMENT		POST-MORTEM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
DATE		TIME	

BUREAU V. S.

SEP 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9353

CERTIFICATE OF DEATH

Reg. Dist. No. 09359

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 39yrs.7mos.16days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1725 Homestead Street	
3. NAME OF DECEASED (Type or print) First Aldyth Middle LONEY Last		4. DATE OF DEATH Month September Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory hand		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Loney		14. MOTHER'S MAIDEN NAME Mary Gise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO 715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Decubitus ulcer DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Weeks Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1950 to September 13, 1957 , that I last saw the deceased alive on September 12, 1957 , and that death occurred at 2:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/13/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9-14-57	London Park	Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Lemard J Ruck		24a. REC'D BY REGISTRAR DATE 9-13-57	24b. REGISTRAR'S SIGNATURE C. Harry Shier

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

RECEIVED
SEP 16 1957
BUREAU V. S.

9354

CERTIFICATE OF DEATH

09360

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN TB 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Kerr Last MILLER				4. DATE OF DEATH Month September Day 2 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter, mechanic		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis Miller				14. MOTHER'S MAIDEN NAME Carrie Belle Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-07-1083		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH Minutes							
DUE TO 420.0							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease Years							
DUE TO (c) Generalized arteriosclerosis Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 1, 1957 , to September 2, 1957 , that I last saw the deceased alive on September 2, 1957 , and that death occurred at 5:45P M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital				9/3/57			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.		22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD	
23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR SEP 9 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Neys			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 3

SEP 9 1957

RECEIVED

9355

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY AMELIA MYERS</u>				4. DATE OF DEATH Month Day Year <u>SEPT 23 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>DANIEL W. MYERS</u>		14. MOTHER'S MAIDEN NAME <u>DOROTHY KING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>DANIEL JONES, LINWOOD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Sclerosis</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General weakness</u> DUE TO (c) <u>Cardiac decompensation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1</u> , 1957, to <u>9-23-</u> , 1957, that I last saw the deceased alive on <u>9-18-</u> , 1957, and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>121 E. Green St Westminster</u>				DATE SIGNED <u>WESTMINSTER MD</u>			
ACTUAL SIGNATURE <u>Dr. C. Stone</u>				M.D. <u>Dr. C. Stone</u>			
PHYSICIAN'S NAME (Type) <u>Dr. C. Stone</u>				<u>WESTMINSTER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Statler</u>				ADDRESS <u>New Windsor, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept 24</u>	
24b. REGISTRAR'S SIGNATURE <u>James S. Benedict</u>				<u>2001 Reg</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 26 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1mo. 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 302 S. Wolfe Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Albert Last MYERS				4. DATE OF DEATH Month September Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Myers				14. MOTHER'S MAIDEN NAME Lucy Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Spanish American				16. SOCIAL SECURITY NO. -			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver.- C.B.S. associated with cerebral arteriosclerosis with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 23, 1957 , to September 10, 1957 , that I last saw the deceased alive on September 10, 1957 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/10/57							
ACTUAL SIGNATURE Agustin del Campo				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 13, 1957			
22c. NAME OF CEMETERY OR CREMATORY Baltimore				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.				24a. REC'D BY REGISTRAR 9/11/57			
24b. REGISTRAR'S SIGNATURE C. Harry Steers							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18

BURKAU V. S.

SEP 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film G220 9-20-57 at
9357 CERTIFICATE OF DEATH

09363

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3mos. 1day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 208 S. Eutaw Street			
3. NAME OF DECEASED (Type or print) First Reginald Middle Mitchell Last NAUGHTON				4. DATE OF DEATH Month September Day 6 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1900	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ritchie Naughton				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute brain syndrome associated with alcoholism						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from June 5, 1957 , to September 6, 1957 , that I last saw the deceased alive on September 6, 1957 , and that death occurred at 1:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt		M.D. Springfield State Hospital		ADDRESS (Street, city or town, state) _____		DATE SIGNED 9/6/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland					
22a. BURIAL CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> REMOVAL	22b. DATE THEREOF 9 19 57	22c. NAME OF CEMETERY OR CREMATORY W. H. Sonnenfeldt		22d. LOCATION (City, town, or county) Baltimore, Md		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell		ADDRESS 1400 N. Charles St.		24a. REC'D BY REGISTRAR SEP 16 1957		24b. REGISTRAR'S SIGNATURE Harry Kepp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

RECEIVED
 SEP 16 1957
 BUREAU V. S.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alexander Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William T Newman			4. DATE OF DEATH Month Sept. Day 26 Year 19 57				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1887		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Newman				14. MOTHER'S MAIDEN NAME Allie M. Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) World War I		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Thomas Muse		Address 9 Fair Ave-Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 731X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pediatric Disease of Bone DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10m							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 26, 1957 to Sept 26, 1957 , that I last saw the deceased alive on Sept 26, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. H. MESSLER M.D.							
PHYSICIAN'S NAME (Type) J. H. MESSLER M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery		22d. LOCATION (City, town, or county) (State) Rural Ladiesburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Russ & Son Michael C. Russ				ADDRESS Taneytown, Md.		24a. REC'D BY REGISTRAR SE DATE 30 1957	
				24b. REGISTRAR'S SIGNATURE Leslie Shepp			

(Faint handwritten notes at the bottom of the page)

CERTIFICATE OF DEATH

Reg. Dist. No.

74

9359

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 mos. 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3417 E. Fairmont Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Albert Middle Frantz Last PAFEL				4. DATE OF DEATH Month September Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 31, 1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 70 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. 217-20-8289A		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis, with psychotic reaction.				INTERVAL BETWEEN ONSET AND DEATH Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis, with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 22, 1956 to Sept. 10, 1957 , that I last saw the deceased alive on Sept. 9, 1956 , and that death occurred at 8:15 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/10/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR DATE Sept. 10, 1957		24b. REGISTRAR'S SIGNATURE Woor & Haight	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

SEP 11 1937

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN IB 22yrs, 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 806 Bradford Street	
3. NAME OF DECEASED (Type or print) First John Middle PODRASKY Last		4. DATE OF DEATH Month September Day 1 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, clerk		10b. KIND OF BUSINESS OR INDUSTRY unk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Podrasky		14. MOTHER'S MAIDEN NAME Anna Pottgieser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type. Old pulmonary tuberculosis.			INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955 , to September 1, 1957 , that I last saw the deceased alive on September 1, 1957 , and that death occurred at 1:55 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED Agustin del Campo, M.D.			
ACTUAL SIGNATURE Agustin del Campo		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9-4-57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 9-4-57	24b. REGISTRAR'S SIGNATURE C. Harry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 6 1957

RECEIVED

9361

CERTIFICATE OF DEATH

09367

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <i>Parroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Parroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Dykeville</i>		c. LENGTH OF STAY IN IB <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Rural - Dykeville x 2</i>	
3. NAME OF DECEASED (Type or print) <i>Augustus Rheubottom</i>		4. DATE OF DEATH <i>Sept 19 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4, 1876</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Basil Rheubottom</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Rosie M. Rheubottom - Dykeville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Cerebro - Sclerosis</i> DUE TO (c) <i>10 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/19</i> , 19 <i>57</i> , to <i>9/19</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>9/19</i> , 19 <i>57</i> , and that death occurred at <i>8:45</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B. Luther Bare</i>		ADDRESS (Street, city or town, state) <i>Dykeville, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>S. LUTHER BARE</i>		DATE SIGNED <i>Sept 19 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>9-22-57</i>	<i>Bushy Park</i>	<i>Dykeville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		ADDRESS <i>Dykeville, Md.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>C. H. Haight</i>	
DATE <i>9-21-57</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. 2

SEP 24 1957

RECEIVED

9362

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural New Windsor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural New Windsor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Ernest</u> Last <u>Roser</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov, 26, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Roser</u>		14. MOTHER'S MAIDEN NAME <u>Alice Harp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-24-5766</u>	
17. INFORMANT <u>Mrs. Nora Roser, New Windsor, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>angina pectoris</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 am 30</u> , 19 <u>56</u> , to <u>Sept. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>aug 28</u> , 19 <u>57</u> , and that death occurred at <u>7 30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>New Windsor, Md.</u> <u>9/3/57</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Robertson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Nr. Uniontown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>		ADDRESS <u>Taneytown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ernie Benedict</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

SEP 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9363

CERTIFICATE OF DEATH

Reg. Dist. No.

09369

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Littlestown 75 x.3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 South Main Street</u>		d. STREET ADDRESS <u>Littlestown, Pa. R.D.1</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Amelia</u> Last <u>Shanebrook</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1870</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home.</u>	
11. BIRTHPLACE (State or foreign country) <u>Adams County, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>P. David Schwartz</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Plank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Rev. Richard S. Shanebrook, Manchester, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>old age</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/19/57</u> , 19 <u>57</u> , to <u>9/29/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/29/57</u> , 19 <u>57</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foard</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>		DATE SIGNED <u>9/29/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Littlestown, Adams Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>		ADDRESS <u>Littlestown, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>Sept 30</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. S. Penn</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Bartholomew J. Smith

BUREAU V. S.

OCT 2 1957

RECEIVED

Bartholomew J. Smith

9364

CERTIFICATE OF DEATH

Reg. Dist. No.

09370 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 y 6 m 19 d			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md				1556.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 10115 Greenock Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Cabell Last Sheehy				4. DATE OF DEATH Month 9 Day 21 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-79	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward J. Sheehy			14. MOTHER'S MAIDEN NAME (unknown) Reidy				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unkn		16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S.Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr.brain syndr.assoc. with cerebral arterioscler. with psych. react							INTERVAL BETWEEN ONSET AND DEATH years years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-2-56 19 56 , to 9-21- 19 57 , that I last saw the deceased alive on 9-21- 19 57 , and that death occurred at 11 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 9-21-57							
ACTUAL SIGNATURE Edmund B. Lusthaus M.D. Springfield State Hospital 9-21-57							
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Humphrey ADDRESS Silver Spring, Md.				24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE C. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9365

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7yrs. 10mos. 29days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 323 S. Castle Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Barbara Middle SMITH Last SMITH				4. DATE OF DEATH Month September Day 4, Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Fondron				14. MOTHER'S MAIDEN NAME Elizabeth Baum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-16-9900			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis and pulmonary tuberculosis, inactive.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 1950 , to September 4, 1957 , that I last saw the deceased alive on September 3, 1957 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/4/57							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 7, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Matthews		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.				24a. REC'D BY REGISTRAR 9/6/57			
24b. REGISTRAR'S SIGNATURE C. Harry Steep							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REARWARD STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

BUREAU V. S.

SEP 9 1957

RECEIVED

INSTRUCTIONS

1 M TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled up by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09372

9366

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Union Bridge</u>		LENGTH OF STAY (in this place) <u>55 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Union Bridge</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) (Middle) (Last) <u>Rhoda L. Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 26, 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April 8, 1881</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Scott McAlister</u>				14. MOTHER'S MAIDEN NAME <u>Annarnary Boone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Carroll R. Smith, Point Pleasant, N.J.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>						<u>8 mos -</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Colon</u>						<u>8 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-13-57</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Colon - Metastasis abdominal wall & abdominal viscera</u>				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 7</u> , 19 <u>57</u> , to <u>Sept 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>57</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James J. Marsh</u>		M.D. <u>William M. T. T. T.</u>		ADDRESS (Street, city, town, state) <u>Thid</u>		DATE SIGNED <u>9/26/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/28/57</u>		NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>	
24. REC'D BY REGISTRAR <u>SEP 30 1957</u>		REGISTRAR'S SIGNATURE <u>Leslie Z. Repp</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>		ADDRESS <u>Taneytown, Maryland</u>	

CERTIFICATE OF DEATH

FILE NO. 100-100000

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text] 3. AGE: [Faint text] 4. DATE OF BIRTH: [Faint text] 5. PLACE OF BIRTH: [Faint text] 6. OCCUPATION: [Faint text] 7. MARITAL STATUS: [Faint text] 8. EDUCATION: [Faint text] 9. RELIGION: [Faint text] 10. RACE: [Faint text] 11. COLOR: [Faint text] 12. ETHNIC ORIGIN: [Faint text] 13. SOCIAL CLASS: [Faint text] 14. INCOME: [Faint text] 15. HOME ADDRESS: [Faint text] 16. CITY: [Faint text] 17. STATE: [Faint text] 18. COUNTRY: [Faint text] 19. DATE OF DEATH: [Faint text] 20. PLACE OF DEATH: [Faint text] 21. CAUSE OF DEATH: [Faint text] 22. MANNER OF DEATH: [Faint text] 23. TIME OF DEATH: [Faint text] 24. TIME OF REPORT: [Faint text] 25. REPORTED BY: [Faint text] 26. SIGNATURE: [Faint text] 27. TITLE: [Faint text] 28. ADDRESS: [Faint text] 29. CITY: [Faint text] 30. STATE: [Faint text] 31. COUNTRY: [Faint text] 32. DATE OF REPORT: [Faint text] 33. PLACE OF REPORT: [Faint text] 34. CAUSE OF REPORT: [Faint text] 35. MANNER OF REPORT: [Faint text] 36. TIME OF REPORT: [Faint text] 37. TIME OF DEATH: [Faint text] 38. TIME OF BIRTH: [Faint text] 39. TIME OF MARRIAGE: [Faint text] 40. TIME OF EDUCATION: [Faint text] 41. TIME OF RELIGION: [Faint text] 42. TIME OF RACE: [Faint text] 43. TIME OF COLOR: [Faint text] 44. TIME OF ETHNIC ORIGIN: [Faint text] 45. TIME OF SOCIAL CLASS: [Faint text] 46. TIME OF INCOME: [Faint text] 47. TIME OF HOME ADDRESS: [Faint text] 48. TIME OF CITY: [Faint text] 49. TIME OF STATE: [Faint text] 50. TIME OF COUNTRY: [Faint text] 51. TIME OF DATE OF DEATH: [Faint text] 52. TIME OF PLACE OF DEATH: [Faint text] 53. TIME OF CAUSE OF DEATH: [Faint text] 54. TIME OF MANNER OF DEATH: [Faint text] 55. TIME OF TIME OF DEATH: [Faint text] 56. TIME OF TIME OF REPORT: [Faint text] 57. TIME OF REPORTED BY: [Faint text] 58. TIME OF SIGNATURE: [Faint text] 59. TIME OF TITLE: [Faint text] 60. TIME OF ADDRESS: [Faint text] 61. TIME OF CITY: [Faint text] 62. TIME OF STATE: [Faint text] 63. TIME OF COUNTRY: [Faint text] 64. TIME OF DATE OF REPORT: [Faint text] 65. TIME OF PLACE OF REPORT: [Faint text] 66. TIME OF CAUSE OF REPORT: [Faint text] 67. TIME OF MANNER OF REPORT: [Faint text] 68. TIME OF TIME OF REPORT: [Faint text] 69. TIME OF TIME OF DEATH: [Faint text] 70. TIME OF TIME OF BIRTH: [Faint text] 71. TIME OF TIME OF MARRIAGE: [Faint text] 72. TIME OF TIME OF EDUCATION: [Faint text] 73. TIME OF TIME OF RELIGION: [Faint text] 74. TIME OF TIME OF RACE: [Faint text] 75. TIME OF TIME OF COLOR: [Faint text] 76. TIME OF TIME OF ETHNIC ORIGIN: [Faint text] 77. TIME OF TIME OF SOCIAL CLASS: [Faint text] 78. TIME OF TIME OF INCOME: [Faint text] 79. TIME OF TIME OF HOME ADDRESS: [Faint text] 80. TIME OF TIME OF CITY: [Faint text] 81. TIME OF TIME OF STATE: [Faint text] 82. TIME OF TIME OF COUNTRY: [Faint text] 83. TIME OF TIME OF DATE OF DEATH: [Faint text] 84. TIME OF TIME OF PLACE OF DEATH: [Faint text] 85. TIME OF TIME OF CAUSE OF DEATH: [Faint text] 86. TIME OF TIME OF MANNER OF DEATH: [Faint text] 87. TIME OF TIME OF TIME OF DEATH: [Faint text] 88. TIME OF TIME OF TIME OF REPORT: [Faint text] 89. TIME OF TIME OF REPORTED BY: [Faint text] 90. TIME OF TIME OF SIGNATURE: [Faint text] 91. TIME OF TIME OF TITLE: [Faint text] 92. TIME OF TIME OF ADDRESS: [Faint text] 93. TIME OF TIME OF CITY: [Faint text] 94. TIME OF TIME OF STATE: [Faint text] 95. TIME OF TIME OF COUNTRY: [Faint text] 96. TIME OF TIME OF DATE OF REPORT: [Faint text] 97. TIME OF TIME OF PLACE OF REPORT: [Faint text] 98. TIME OF TIME OF CAUSE OF REPORT: [Faint text] 99. TIME OF TIME OF MANNER OF REPORT: [Faint text] 100. TIME OF TIME OF TIME OF REPORT: [Faint text]

BUREAU V. S.

SEP 30 1957

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

9367

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Victorine Emilie Middle L'Homme Last SMITH				4. DATE OF DEATH Month September Day 25 , Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emile L'Homme				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 491X						INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield State Hospital	(County)	(State)		
21. I certify that I attended the deceased from September 13, 1957 to September 25, 1957 , that I last saw the deceased alive on September 24, 1957 , and that death occurred at 4:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt		M.D. Springfield State Hospital		DATE SIGNED 9/25/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9/28/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR SEP 26 1957		24b. REGISTRAR'S SIGNATURE Harry Weir		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page No. 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
MARRIAGE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY			
JAMES EARL RAY		MARRIED		JAN 15 1950		MOBILE		ALABAMA		UNITED STATES		UNITED STATES			
OCCUPATION		PROFESSION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
MEMBER OF ARMY		PROFESSION		JAN 4 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES			
CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY			
HEART DISEASE		NATURAL		JAN 4 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES			
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY		STATE		COUNTRY			
JAMES EARL RAY		JAMES EARL RAY		JAN 4 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES			

BUREAU V. 1

SEP 26 1957

RECEIVED

9368

CERTIFICATE OF DEATH

Reg. Dist. No.

50

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>NEW WINDSOR X2</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>LOU</u> Last <u>SNADER</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EL HANNAN ENGLAR</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BUCKEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>PHILIP B. SNADER</u>		Address <u>NEW WINDSOR MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastric enteritis</u> <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-10-</u> , 19 <u>57</u> , to <u>Sept 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 13</u> , 19 <u>57</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Union Bridge Md</u> <u>9-14-57</u>			
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.		PHYSICIAN'S NAME (Type) <u>Thomas H. Legg, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. O. [illegible]</u>		ADDRESS <u>NEW WINDSOR MD</u>	
24a. REC'D BY REGISTRAR <u>Sept 14 '57</u>		24b. REGISTRAR'S SIGNATURE <u>[illegible]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y. I.

SEP 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09375

9369

CERTIFICATE OF DEATH

Reg. Dist. No.

712

1. PLACE OF DEATH o. COUNTY <u>CARROLL CO. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALTONA</u>			
c. LENGTH OF STAY IN 1b <u>1 WEEK</u>				d. STREET ADDRESS <u>118 LANDIS, ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OLD BALTIMORE ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE LORRAINE STANDER</u>			4. DATE OF DEATH Month Day Year <u>SEPT 8 1957</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 29, 1901</u>	9. AGE (In years last birthday) yrs. <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES ALBERT PEELING</u>			14. MOTHER'S MAIDEN NAME <u>SAELLA BARNES</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ALLISON PEELING, WESTMINSTER, MD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Pericardiomatosis Abdomen</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases from Carcinoma Uterus</u> DUE TO (c) <u>5 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/5</u> , 19 <u>57</u> , to <u>9/8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/8</u> , 19 <u>57</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederick Bare</u>			M.D. <u>Westminster Maryland</u>		DATE SIGNED <u>9/9/57</u>		
PHYSICIAN'S NAME (Type) <u>S. LUTHER BARE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 11, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FINKSBURG, CEM.</u>		22d. LOCATION (City, town, or county) <u>FINKSBURG, MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Rogers, Jr. Westminster, Md.</u>			ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>DATE 9-11-57</u>	24b. REGISTRAR'S SIGNATURE <u>Frederick Miller</u>	

BUREAU V. S.

SEP 13 1957

RECEIVED

9370

CERTIFICATE OF DEATH

09376

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>RURAL WESTMINSTER XI</u>	
c. LENGTH OF STAY IN 1b <u>59 YRS</u>		d. STREET ADDRESS <u>TPD 7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TPD 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ARTHUR DIEHL STARNER</u>		4. DATE OF DEATH <u>SEPT. 17 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB D. STARNER</u>		14. MOTHER'S MAIDEN NAME <u>JESSIE DAYHOFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-01-0558</u>	
17. INFORMANT <u>BESSIE M. STARNER</u>		Address <u>RD 7 WESTMINSTER, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis (Heart)</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>From Heart</u> <u>General</u> <u>Yes</u> <u>104.10</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 13, 1957</u> to <u>Sept 17, 1957</u> ; that I last saw the deceased alive on <u>Aug 3, 1957</u> ; and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Seun Speicher</u>		ADDRESS (street, city or town, state) <u>Westminster, Md</u>	
PHYSICIAN'S NAME (Type) <u>W. L. Seun Speicher</u>		DATE SIGNED <u>9/15/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-21-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WARRIERS CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David R. Bankard</u>		ADDRESS <u>Westminster</u>	
24a. REC'D BY REGISTRAR <u>David R. Bankard</u>		24b. REGISTRAR'S SIGNATURE <u>David R. Bankard</u>	
DATE <u>9-20-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

SEP 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9371

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03x2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 29 Murdock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Vandersloot				4. DATE OF DEATH Month 9 Day 14 Year 1957			
5. SEX Male MX F		6. COLOR OR RACE W W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-27-02	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) filling machine helper				10b. KIND OF BUSINESS OR INDUSTRY Mattress Co		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward R. Vandersloot				14. MOTHER'S MAIDEN NAME Elsie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Unkn		17. INFORMANT S.S.Hosp. Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive biliary cirrhosis 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Calculus of gall bladder DUE TO (c) months months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive psychosis, Hypomanic phase							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-14- 1956 , to 9-13- 1957 , that I last saw the deceased alive on 9-13- 1957 , and that death occurred at 3:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9-14-57							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Edmund Lusthaus				SYKESVILLE, MARYLAND.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT-17, 1957		22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE		22d. LOCATION (City, town, or county) (State) BALTIMORE - MD	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, INC - Towson, MD				24a. REC'D BY REGISTRAR DATE 9-14-57		24b. REGISTRAR'S SIGNATURE C. Henry Allen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and difficult to read.

RECEIVED
SEP 18 1957
BUREAU V. 1

9372

CERTIFICATE OF DEATH

09378 14

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Fork School House Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rosie Middle Leola Last Vaughn				4. DATE OF DEATH Month September Day 30 Year 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17 1883		9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George T Bean				14. MOTHER'S MAIDEN NAME Rebecca Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address George W Vaughn Hampstead Rt 1 Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Anterior and posterior Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 5 days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/17 19 57 , to 9/30 19 57 , that I last saw the deceased alive on 9/29 19 57 , and that death occurred at 1:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Manchester, Md DATE SIGNED 9/30/57							
ACTUAL SIGNATURE W H Foard				M.D. MANCHESTER, MD			
PHYSICIAN'S NAME (Type) W H Foard, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 2 1957		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Berryman & Sons				24a. REC'D BY REGISTRAR DATE 9-30-57		24b. REGISTRAR'S SIGNATURE Mary B. Elmer Mrs. W. B. Berryman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09379

9373

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROADWAY</u>		d. STREET ADDRESS <u>1 BROADWAY</u>	
3. NAME OF DECEASED (Type or print) First <u>VINNIE</u> Middle <u>CAROLINE</u> Last <u>WAREHIME</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/17/1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL BENEDICT</u>		14. MOTHER'S MAIDEN NAME <u>LAVINIA BENEDICT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>GLENN WAREHIME</u> Address <u>KEYMAR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic food poisoning</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>57</u> , to <u>Sept 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 28</u> , 19 <u>57</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.		DATE SIGNED <u>10/1/57</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		<u>Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 2-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BAUST CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons</u> ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>10/2/57</u> 24b. REGISTRAR'S SIGNATURE <u>Philip L. Repko</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

OCT 3 1957

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9374

CERTIFICATE OF DEATH

09389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy				c. LENGTH OF STAY IN 1b 70 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Mt. Airy x2				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ISAAC Middle M. Last WATERS				4. DATE OF DEATH Month Sept. Day 3 Year 1957			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Misc.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard Waters				14. MOTHER'S MAIDEN NAME Elizabeth Richardson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Roberta Dorsey,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chron. nephritis with General Debility 592x DUE TO of age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Cardiac Failure DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Aug 31, 1957 , to Sept 3, 1957 , that I last saw the deceased alive on Aug 31, 1957 , and that death occurred at 2 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. M. Var Pool				ADDRESS (Street, city or town, state) Mt Airy Md		DATE SIGNED 9-4-57	
PHYSICIAN'S NAME (Type) C. M. Var Pool							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-7-1957		22c. NAME OF CEMETERY Mt. Zion		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR 9 1957	
				24b. REGISTRAR'S SIGNATURE Edna Smith			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

My Office

County

City

State

Residence

TO THE

DEATH

DATE

TIME

PLACE

NAME

AGE

SEX

RESIDENCE

CAUSE

PLACE

TIME

DATE

BUREAU V. S.

SEP 9 1957

RECEIVED

9375

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Last YANIK				4. DATE OF DEATH Month September Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Andrew Yanik				14. MOTHER'S MAIDEN NAME Ahnie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Springfield State Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis.						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-25 19 57 , to 9-9 19 57 , that I last saw the deceased alive on September 9 19 57 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hospital				PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9-12-57		new Catholic		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Haight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 9-12-57	
						24b. REGISTRAR'S SIGNATURE C. H. H. H.	

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ARMY AND STATE DEPARTMENT - BALTIMORE, MD

SEP 16 1957

RECEIVED